FIS 0284 (11/02) Office of Financial & Insurance Services Provider Tax ID number (FEIN) Clean Claim Report You may file this report for an individual claim if it is a payable clean claim. It must be a claim filed with a Health Care Plan for a covered service. Provider's Plan ID Number If claim meets each of these conditions, continue. Member's ID number If claim does not meet each condition, you may not file this report. (Not member's Medicaid ID) **Provider Name Procedure Code Provider Address** ICD-9-CM Diagnosis Code Authorization No. (if required City State Zip for particular service) Important Note: Format all dates as MM/DD/YY **Health Care Plan Name Date of Service Date Provider billed Plan Member Name** 1. Did Provider have proper plan authorization (including authorization number) at the time of service, if required? 2. Did Provider use a clearinghouse to check for completeness of claim form? 3. Did Provider verify plan membership of patient at time of service? 4. Did Provider verify Primary Care Provider (PCP) status at the time of service if required? 5. Did Health Care Plan communicate any denial of your request for payment? If Yes, skip 5A. If No, complete 5A and skip to 7. 5A. If Health Care Plan did not respond to the request for payment, describe any proof you have that they received the claim: 6. Reason given by Health Care Plan for denial of payment: Explain in words. Do not use Plan rejection codes! 6A. Date of 1st denial by plan 7. Was a second denial received? 7C. Date 2nd claim submitted 7A. If yes, was corrected information given? 7B. Reason given by Health Care Plan for 2nd denial of payment: 7D. Date of 2nd denial by plan 8. Have you discussed this claim with Health Care Plan staff? Yes No 8A. If Yes, what was the Plan's explanation (if any) for the claim rejection? 9A. Date of notification 9. Did you send a copy of this report to the Health Care Plan? Yes If Yes, complete 9A. If No, your clean claim report processing will be delayed.

Certification: I certify that this information is complete and correct. I have followed the requirements of Public Act 316 of 2002. This claim is a payable clean claim that met all required timelines for claims submission under the act.

Date signed

an required unfellines for claims submission under the act.

Attach any additional information that provides facts or proof that will assist us in settlement of this

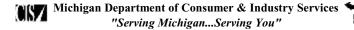
claim. Any such attachments are subject to the above certification of Provider or representative.

PA 316 of 2002 as amended requires submission of this form by any provider seeking relief for clean claims not paid in a timely manner as described in the act.

Signer's name and title typed or printed

Visit OFIS on the Web at: www.michigan.gov/ofis

Signature of Provider or represenative



Phone OFIS toll-free at: 1-877-999-6442